



Vision Benefits – Claim Instructions

Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to claim was provided by the applicant.

California Residents: For your protection, California law requires notice of the following: Any person who knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime and may be subject to fines, confinement in a state prison and substantial civil penalties.

Colorado Residents: **An insurer or agent who knowingly provides false or misleading information to defraud a claimant regarding insurance proceeds must be reported to the Insurance Division.**

Pennsylvania Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

NOTE: INCOMPLETE CLAIM FORMS WILL BE RETURNED TO YOU FOR MISSING INFORMATION. THIS WILL DELAY THE PROCESSING OF THE CLAIM. FOR FASTER, EASIER SUBMISSION OF CLAIMS, THE PROVIDER MAY CONTACT THE AETNA CLAIM PROCESSING CENTER FOR INFORMATION REGARDING ELECTRONIC CLAIM SUBMISSIONS.

TO THE EMPLOYEE

1. Complete items one (1) through twenty-seven (27) in full. Be certain to sign the authorization to release information block (28).
2. If you wish to have your benefits for this claim paid directly to the doctor and/or dispenser, sign the block (29).
3. If you have submitted a request for benefits to another plan, including Medicare, attach a copy of the bills you submitted to the other plan and the explanation of benefits you received from the other plan.
4. Incomplete forms will delay payment
5. Send the completed benefits request and the bills to the Aetna office that services your employer.

TO THE DOCTOR

1. Complete items thirty (30) through forty-three (43) in full.
2. If the employee indicates that benefits should be paid directly to the doctor, then these benefits will be sent directly to you with an information copy of the transactions to the employee.

TO THE DISPENSER

1. Complete items forty-four (44) through fifty-three (53) in full.
2. If the employee indicates that benefits should be paid directly to the dispenser, then these benefits will be sent directly to you with an information copy of the transactions to the employee.



44. Dispenser's Name & Address (include zip code) _____ _____ _____		45. Telephone Number () _____		46. Enter the taxpayer identifying number to be used for 1099 reporting purposes. You are required under authority of law to furnish your taxpayer identifying number. _____																															
		47. Title <input type="checkbox"/> Optician <input type="checkbox"/> Optometrist <input type="checkbox"/> Ophthalmologist																																	
		48. Date <input type="checkbox"/> Order _____ <input type="checkbox"/> Delivery _____		49. Material Supplied <input type="checkbox"/> Glass <input type="checkbox"/> Plastic <input type="checkbox"/> Oversized <input type="checkbox"/> Tint # _____ <input type="checkbox"/> Pair <input type="checkbox"/> 1/2 Pair <input type="checkbox"/> Other _____																															
50. Type of lenses dispensed: <input type="checkbox"/> None <input type="checkbox"/> Single (HCPC/CPT) _____ <input type="checkbox"/> Bifocal (HCPC/CPT) _____ <input type="checkbox"/> Trifocal (HCPC/CPT) _____ <input type="checkbox"/> Lenticular (HCPC/CPT) _____ <input type="checkbox"/> Contacts (HCPC/CPT) _____ <input type="checkbox"/> Sunglasses (HCPC/CPT) _____ <input type="checkbox"/> Other (specify below) (HCPC/CPT) _____ _____		51. If contact lenses, please complete <input type="checkbox"/> Therapeutic (HCPC/CPT) _____ <input type="checkbox"/> Non-Therapeutic (HCPC/CPT) _____ <input type="checkbox"/> Hard Lenses (HCPC/CPT) _____ <input type="checkbox"/> Soft Lenses (HCPC/CPT) _____ 51a. If frames, please complete <input type="checkbox"/> Frames (HCPC/CPT) _____		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th colspan="2" style="text-align: left;">52. Professional Service</th> <th style="text-align: left;">Amount</th> </tr> <tr> <td style="width: 60%;"></td> <td style="text-align: right;">Lens Charge</td> <td style="text-align: right;">\$ _____ _____</td> </tr> <tr> <td></td> <td style="text-align: right;">Frame Charge</td> <td style="text-align: right;">\$ _____ _____</td> </tr> <tr> <td style="text-align: right;">Optional</td> <td style="text-align: right;">Lens</td> <td style="text-align: right;">\$ _____ _____</td> </tr> <tr> <td></td> <td style="text-align: right;">Frame</td> <td style="text-align: right;">\$ _____ _____</td> </tr> <tr> <td style="text-align: right;">Disp. Fee</td> <td style="text-align: right;">Lens</td> <td style="text-align: right;">\$ _____ _____</td> </tr> <tr> <td></td> <td style="text-align: right;">Frame</td> <td style="text-align: right;">\$ _____ _____</td> </tr> <tr> <td></td> <td style="text-align: right;">Sales Tax (if any)</td> <td style="text-align: right;">\$ _____ _____</td> </tr> <tr> <td></td> <td style="text-align: right;">Total</td> <td style="text-align: right;">\$ _____ _____</td> </tr> <tr> <td></td> <td style="text-align: right;">Amount Paid By Patient</td> <td style="text-align: right;">\$ _____ _____</td> </tr> </table>		52. Professional Service		Amount		Lens Charge	\$ _____ _____		Frame Charge	\$ _____ _____	Optional	Lens	\$ _____ _____		Frame	\$ _____ _____	Disp. Fee	Lens	\$ _____ _____		Frame	\$ _____ _____		Sales Tax (if any)	\$ _____ _____		Total	\$ _____ _____		Amount Paid By Patient	\$ _____ _____
52. Professional Service		Amount																																	
	Lens Charge	\$ _____ _____																																	
	Frame Charge	\$ _____ _____																																	
Optional	Lens	\$ _____ _____																																	
	Frame	\$ _____ _____																																	
Disp. Fee	Lens	\$ _____ _____																																	
	Frame	\$ _____ _____																																	
	Sales Tax (if any)	\$ _____ _____																																	
	Total	\$ _____ _____																																	
	Amount Paid By Patient	\$ _____ _____																																	
53. I hereby certify that I have performed the services as indicated hereon and that the fees submitted are the actual fees I have charged this patient and intend to accept for those procedures. <div style="display: flex; justify-content: space-between;"> Dispenser's Signature _____ Date _____ </div>																																			